LOUISIANA ADVANCE DIRECTIVES

Legal Documents

To Make Sure Your Choices for Future Medical Care or the Refusal of Same are Honored and Implemented by Your Health Care Providers

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ADVANCE DIRECTIVES

INTRODUCTION

Advance Directives are legal documents designed to ensure that your decisions concerning your medical care, including the right to refuse treatment, are understood and followed by your health care providers if you become physically or mentally unable to make these decisions on your own.

Both state and federal law require health care institutions and physicians to respect the wishes of a patient over eighteen years old concerning medical care, including the right to accept or refuse treatment and to discontinue treatment.

The law also allows you to designate an individual to make decisions about your medical care and treatment if you are physically or mentally unable to do so on your own. The purpose of this booklet is to explain the process and the different options available to you.

This is an important matter, and you should talk to your spouse, family, close friends, your physician and your attorney before deciding whether or not you want an advance directive.

GENERAL INFORMATION

What are "Advance Directives"?

Advance Directives are legal documents that explain your choices about medical treatment or designate someone to make decisions about your medical treatment if you are incapacitated. These documents are referred to as "advance" directives because they are prepared in advance so that your health care providers will know your wishes concerning medical treatment.

Louisiana law recognizes 2 types of advance directives:

1) A Living Will (also known as a Declaration); and
2) A Durable Power of Attorney for Health Care.

LIVING WILL (DECLARATION)

A living will is also referred to as a "declaration." It is a declaration by an adult person directing the withholding or withdrawal of life-sustaining procedures in the event such person should have a terminal and irreversible condition. A living will can be in writing or in the form

of an oral or nonverbal declaration. If it is in writing, the written declaration must be signed by you in the presence of two witnesses. An oral or nonverbal declaration may be made by an adult in the presence of two witnesses at any time after the diagnosis of the terminal and irreversible condition.

What is a "terminal and irreversible" condition?

A terminal and irreversible condition is defined as a continual profound comatose state (with no reasonable chance of recovery) or an incurable condition caused by injury, disease, or illness for which, within reasonable judgment, the administration of medical treatment or intervention would only prolong the dying process.

What are "Life-Sustaining" procedures?

A life-sustaining procedure is any medical procedure or treatment which only prolongs the dying process and does not cure or improve the terminal and irreversible condition. Some examples of life-sustaining procedures include the administration of cardio-pulmonary resuscitation (CPR), machines which perform the function of breathing for you (ventilators), and invasive administration of food and water. A "life-sustaining procedure" does not include any measure which is necessary to provide comfort care.

Who can witness my Living Will?

Any competent adult who is not related to you by blood or marriage and who would not be entitled to any portion of your estate may be a witness. The living will does not have to be notarized by a notary public.

When does my Living Will become effective?

Your living will becomes effective when the following three conditions are met:

1) Your health care provider has a copy of your living will,
2) Your physician and one other physician have determined that you are no longer able to make your own decisions concerning medical treatment and health care, and
3) Your physician and one other physician have determined that you are in a continual profound comatose state or have a terminal and irreversible condition.

A "Do Not Resuscitate" (DNR) order is not the same thing as a Living Will

A Do Not Resuscitate ("DNR") order is an order entered in your medical record by your physician at your request. A DNR provides that if you have a cardiac arrest (your heart stops beating) or a respiratory arrest (you stop breathing), your health care providers will not try to revive you by any means. A living will is broader than a DNR because the DNR only covers these two situations. A living will is designed to cover all types of life-sustaining treatments and procedures after you develop a terminal and irreversible condition.

If I have a Living Will, am I able to receive medication for pain?

Yes. Pain medication is considered comfort care. Unless you specifically state in your living will that you do not want pain medication, your physician will continue to provide pain medication as appropriate to ensure your comfort.

Can my physician be held liable for following my instructions?

Your physician or health care providers cannot be held criminally or civilly liable for following the instructions of your living will including the withholding or withdrawal of life-sustaining procedures.

Does a living will jeopardize my insurance coverage?

No.

Do I have to record my living will?

Louisiana law does not require you to record your living will. You should make sure that all of your health care providers have a copy of your living will. If you wish to register your living will with the Secretary of State, send either a certified copy or the original living will to the following address:

Office of Secretary of State
P.O. Box 94125
Baton Rouge, LA 70804-9125

The current fee for registration is $20.00. If you have questions concerning the registration, you may contact the Office of the Secretary of State at (225) 922-0257.

Can I revoke my living will?

Yes. A living will may be revoked at any time. You may revoke your living will by destroying the original document or by preparing a written revocation expressing your wish to revoke the living will. This should be signed and dated by you. You must make your health care providers and family members aware of the fact that you have revoked your living will. If you have registered your living will with the Secretary of State, you may revoke your living will by filing a written notice of revocation with that office. You may also revoke your living will by an oral or nonverbal expression and this revocation becomes effective upon communication to your attending physician. The attending physician is required to record in your medical record the time and date when the notification of revocation was received.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

A Durable Power of Attorney ("DPAHC") is a legal document by which you authorize another person (an agent or attorney-in-fact) to make health care decisions in the event that you become temporarily or permanently unable to make those decisions for yourself. These can include health care decisions concerning surgery, medical expenses, nursing home residency, and medication administration. You will need a lawyer to help you draft this document.

Who is eligible to be appointed as my attorney-in-fact or agent?

You may appoint any competent adult to be your agent or attorney-in-fact. The individual you select does not have to be an attorney. You should make sure that the person you select has an understanding of your wishes and is comfortable accepting the responsibility. Members of your family are the most common choices for the agent or attorney-in-fact. It is usually best not to appoint a treating health care provider as your agent or attorney-in-fact in order to avoid a potential conflict of interest. Your agent or attorney-in-fact can resign at any time upon giving written notice to you, your doctor, or the health care facility where you are being treated.

When does the Durable Power of Attorney for Health Care become effective?

The DPAHC only comes into play if you are temporarily or permanently unable to make your own health care decisions. If, after the DPAHC becomes effective, your treating physician determines that you have regained the capacity to make your own health care decisions, then your agent's authority ends and your consent is required for all future health care decisions. If you later become incapacitated again, then the DPAHC will once again become effective.

What type of decisions does my DPAHC cover?

You have the ability to control the decisions your agent is able to make in the event you become incapacitated. If you do not limit your agent's authority, then your agent will be able to make the same decisions concerning medical treatment and intervention that you would be permitted to make if you were not incapacitated. These decisions can include with your authorization, the withholding or withdrawal of treatment and life-sustaining procedures.

Can I appoint more than one individual as agent?

Yes. The law allows you to designate alternatives in the event that your first choice is unable or unwilling to act. Your agent cannot be compensated for the performance of his or her duties pursuant to the DPAHC but may be entitled to the reimbursement of expenses incurred in the performance of his or her duties pursuant to the DPAHC. The DPAHC must be signed by you and dated. Your signature must be witnessed by two adults or you may sign the document in front of a notary public. The only people who cannot serve as witnesses are people related to you by blood or marriage or people entitled to inherit from you.

Can my agent be held criminally or civilly liable?

Your agent cannot be held criminally or civilly liable based on treatment decisions made in good faith on your behalf. Your agent also is not responsible for the cost of your medical care and treatment simply because he or she is your agent.

What are the differences between the DPAHC and the Living Will?

The living will only comes into play if you are in a continual profound comatose state or are terminally ill. The DPAHC allows you to appoint an agent to make all medical decisions in the event that you become incapacitated. The DPAHC is broader and gives your agent the authority to respond to unanticipated medical situations.

What happens if I don't have Advance Directives?

Advance Directives are not required. If you do not have one and are unable to make decisions for yourself then your health care providers will consult with the following people in the order listed:

1. Your legal guardian
2. Your spouse
3. Your adult children
4. Your parents
5. Your brothers or sisters or any other relative you might have.

How do my health care providers know whether I have Advance Directives?

All health care facilities that receive federal funding must ask if you have advance directives, and if so, they must be placed in your medical chart.

Are health care providers required to follow my Advance Directives?

Generally, yes, if your Advance Directives comply with the law. The law requires your health care providers to give you their written policies concerning advance directives. A summary statement of those policies is at the end of this document. It is possible that your doctor or other health care provider cannot or will not follow your advance directives for moral, religious or professional reasons, even though they comply with Louisiana law. If this occurs, your health care providers must immediately notify you. The law requires them to help you transfer to another doctor or facility that will honor your choices.

LOUISIANA LIVING WILL DECLARATION

Declaration made this _______ day of_________ , ______ (month, year).

I, ____________________________ , being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

If at any time I should have an incurable injury, disease, or illness, or be in a continual profound comatose state with no reasonable chance of recovery, certified to be a terminal and irreversible condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to prolong artificially the dying process,

I direct:

(Initial only one)

_____ that all life-sustaining procedures, including nutrition and hydration be withheld or withdrawn so that food and water will not be administered invasively.

_____ that life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I further direct that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

DECLARANT SIGNATURE

I understand the full import of this Declaration and I am emotionally and mentally competent to make this Declaration.

Signed ____

City, Parish and State of Residence ______________________________________

WITNESS SIGNATURES

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness ____

Witness ____

Should any specific directions be held to be invalid, such invalidity shall not effect other directions of the declaration which can be given effect without the invalid direction, and to this end the directions in the declaration are severable.

A SUMMARY STATEMENT OF HEALTH CARE POLICIES REGARDING PATIENTS' RIGHTS OF SELF-DETERMINATION

(Since a summary like this cannot answer all possible questions or cover every circumstance, you should discuss any remaining questions with a representative of this health care facility.)

1. Prior to the start of any procedure or treatment, the physician shall provide the patient with whatever information is necessary for the patient to make an informed judgment about whether the patient does or does not want the procedure or treatment performed. Except in an emergency, the information provided to the patient to obtain the patient's consent shall include, but not necessarily be limited to, the intended procedure or treatment, the potential risks, and the probable length of disability. Whenever significant alternatives of care or treatment exist, or when the patient requests information concerning alternatives, the patient shall be given such information. The patient shall have the right to know the person responsible for all procedures and treatments.
2. The patient may refuse medical treatment to the extent permitted by law. If the patient refuses treatment, the patient will be informed of significant medical consequences that may result from such action.
3. The patient will receive written information concerning his or her individual rights under Louisiana state law to make decisions concerning medical care.
4. The patient will be given information and the opportunity to make advance directives--including, but not limited to, a Louisiana Living Will Declaration and a Durable Power of Attorney for Health Care.
5. The patient shall receive care regardless of whether or not the patient has or has not made an advance directive.
6. The patient shall have his or her advance directive(s), if any has been created, made a part of his or her permanent medical record.
7. The patient shall have all of the terms of his or her advance directive(s) complied with by the health care facility and caregivers to the extent required or allowed by law.
8. The patient shall be transferred to another doctor or health care facility if his or her doctor(s), or agent of his or her doctor(s), or the health care facility cannot respect the patient's advance directive requests as a matter of "conscience."
9. The patient shall receive the name, phone number and address of the appropriate state agency responsible for receiving questions and complaints about these advance directive policies.

WALLET CARDS FOR LOUISIANA ADVANCE DIRECTIVES

Cut out and complete the cards below. Put one card in the wallet or purse you carry most often, along with your driver's license or health insurance card. You can keep the second card on your refrigerator, in your motor vehicle glove compartment, a spare wallet or purse, or other easy-to-find place.

ATTN: LOUISIANA HEALTH CARE PROVIDERS
I have created the following Advance Directives:
(Check one or more, as appropriate)
_______ Louisiana Declaration
_______ Durable Power of Attorney for Health Care
_______ Other ______________________________

Please contact ______________________________
(Name) (Address) (Telephone)
for more information.

____
(Signature) (Date)

ATTN: LOUISIANA HEALTH CARE PROVIDERS
I have created the following Advance Directives:
(Check one or more, as appropriate)
_______ Louisiana Declaration
_______ Durable Power of Attorney for Health Care
_______ Other ______________________________

Please contact ______________________________
(Name) (Address) (Telephone)
for more information.

____
(Signature) (Date)

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name ______ Date of Birth ______ Medical Record Number ______

Address ______ City ______ State ______ Zip ______ Telephone Number ______ Email Address ______

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information ______

Agency or Individual(s) Authorized to Receive my Health Information ______

Address ______ City ______ State ______ Zip ______ Telephone Number ______

Health Information that may be used / disclosed is limited to the following: ❑ Progress Notes ❑ Emergency Room Record
❑ Discharge Summary ❑ History & Physical ❑ Consultation(s) ❑ Lab ❑ Pathology Report
❑ Operative Note(s) ❑ Imaging/X-Ray ❑ X-Ray Reports ❑ Entire Record
❑ Other *(specify)* ______

Health Information that may be used / disclosed is limited to the following periods of healthcare:
From (date): ______ To (date): ______ Account Number: ______
From (date): ______ To (date): ______ Account Number: ______

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):
❑ Treatment/Consultation ❑ At Request of Patient ❑ Research ❑ Marketing ❑ Billing or Claims Payment
❑ At Request of Employer ❑ Other ______

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

❑ **Yes** ❑ **No** If applicable, I agree to the release of my medical or billing records containing the **sensitive information** listed above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically *expire 60 days* after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature*		Date	Time
Relationship to Patient / Authority to Act on Patient's Behalf		Interpreter, if Utilized	
Witness's Signature	Date	Time	Expiration Date or Event

❑ **Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.*

❑ Electronic copy requested.

Authorization to Use and Disclose
Protected Health Information

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WHITE - Medical Record CANARY - Recipient

Patient Label